PRV – Outreach Interim Payments

Purpose:

To process for payment of interim inpatient hospital claims.

Identification of Roles:

Provider Services: Liaison between provider and IME
Department of Human Services (DHS) Provider Services Unit Manager: Reviews request for approval or denial
Assistant Medicaid Director: Request for approval or denial
Core: If request is approved, will process the claim per instructions below

Performance Standards:

None

Path of Business Procedure:

Step 1: Provider sends request for partial payment to the IME

a. The Provider Services Unit Manager will consider the request if the following conditions are met:
    1. Member has been inpatient for at least 120 days, *and*
    2. Member is expected to be inpatient for at least another 60 days, *and*
    3. Charges are currently over $1M
b. Request should include:
    1. Member's name, state identification number, and date of admission
    2. Brief summary of the case
    3. A current listing of the charges
    4. A physician's attestation that the member has been
        a. inpatient for 120 days, and
        b. is expected to remain in the hospital for a period of no less that 60 additional days
c. Request, plus documentation, will be sent to the IME at:

Iowa Medicaid Enterprise
PO Box 36450
Des Moines, IA 50315

Step 2: Once the request appears in the Correspondence queue, Provider Services phone staff will forward the request to an Education and Outreach Team member through Onbase

a. The phone staff member will also notify the Outreach member via e-mail

Step 3: Outreach member will print and forward a paper copy of the request to the Provider Services Unit Manager for approval or denial

Step 4: Provider Services Unit Manager reviews the request and either approves or denies the request

Step 5: Unit Manager will forward the paper request form to the Assistant Medicaid Director for either approval or denial

a. If approved, approval is communicated to Outreach member
    1. Outreach member contacts the provider with instructions on how to submit claim to the attention of the Outreach staff member
    2. Go to Step 6
b. If denied, denial is communicated to the Outreach member
    1. Outreach member contacts the provider

Step 6: Outreach member receives the claim, and a special batch form will be attached with the following instructions:

a. Why is special batch being requested?
    1. Interim claim approved by DHS Policy to pay
b. Provide detailed instruction on how to process the claim
    1. Force edits 500 and 661
    2. Core:
        a. Change the type-of-bill to 111
        b. Change the status code to 01
        c. Press Enter (to populate the allowable charge)
        d. Change the allowable charge source to “M”
        e. Change the type-of-bill back to 112
        f. Change status code back to 30
        g. Force edits

Step 7: This step will happen once the member is discharged

a. Provider will complete a claim inclusive of all charges and entire date range of inpatient confinement, including those dates and charges already paid
b. Provider will complete an adjustment form to include with the new claim:
    1. Adjustment form will be completed in accordance with established guidelines
    2. Section 5 will indicate a new date range
    3. Section 5 will indicate additional charges
c. Provider will mail the Adjustment form and claim form to the address for adjustments
    1. There is no need to special handle this transaction

Forms/Reports:

Special Batch Form
Adjustment Form

RFP References:

N/A

Interfaces:

Provider Services correspondence address
Outreach staff
DHS staff
MMIS claim payment system
Provider Services Unit Manager
Assistant Director of Medicaid

Attachments:

N/A